Special Article

Speculations on the Impact of Prospective Pricing and DRGs

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Medicare's new Prospective Payment System (PPS) has probably generated more speculation about its potential impact than any other recent development in health care. There is almost universal consensus that PPS will have a major influence on the delivery of health care, but there is also relatively little hard evidence on which to predict what direction that influence will take. For example, the New Jersey all-payer system, on which PPS is loosely based, has been in operation only since 1980; furthermore, there are enough major differences between the two programs to make it risky to generalize from one to the other. Health maintenance organizations (HMOs) have used prospective pricing for years, but their experience is also inapplicable to noncapitated prospective systems. Thus almost any prediction about the influence of PPS must be at least somewhat conjectural.

The end product of the health care system is services to patients, so in the long run it probably will be patients who feel the strongest impact from prospective pricing. However, the major impetus for prospective pricing comes from third-party payers' declared or expressed desire to contain their costs and is carried out by influencing the incentives of providers. This report traces the progression from a payer's (in this case, Medicare's) objectives through providers' behavior to their influence on patients.

Impacts on the Payer

Prospective pricing stems mainly from the payer's objective of controlling health care costs. (Although prospective pricing is intended merely to slow the nationwide rate of growth in costs to the payer, rather than to achieve a reduction in absolute cost levels, high-cost providers will nevertheless experience actual declines in amounts paid over the course of the phase-in period.) The mechanism is the setting of limits on particular units of service (payment units) and placing providers at risk for costs they incur over that limit. In prospective systems the price is based on some measure of providers' costs. Thus, over time the "ceiling" effect of the price should depress the rate of cost increases and be reflected in later prices.

Cost Containment

A basic question about prospective pricing is whether it achieves its cost containment objective. Evidence from states with *all-payer* prospective systems indicates that hospital prices there increase more slowly than they do in the rest of the country.* It is important to note, however, that under all-payer systems (as opposed to the single-payer PPS), hospitals must reduce costs because they have little opportunity to shift them from one payer to another.

There are other related questions as well. Does cost containment for inpatient services generate increased outpatient utilization and cost? Does reduction of inpatient service and length of stay lead to cost-ineffective readmission or complications during the stay? Can "gaming" or manipulation of the system actually increase net cost over what it would have been under cost-based reimbursement? It will take some time to find the answers to questions like these.

Cost Shifting

For payers, the most important implication of prospective pricing is that any payer not included in the system can become a victim of cost shifting. A hospital that cannot break even on a prospective rate from one payer will seek to recover the loss from other payers. Medicare's PPS, for example, may well cause hospitals to shift costs to private-sector payers.

The threat of increased cost-shifting may lead payers to press for state-level all-payer systems such as New Jersey's. Such systems promote a degree of equity among payers by imposing uniformity in the formula for determining the prospective rates. They may not

*New Jersey had lower than average hospital cost inflation before implementation of its prospective system, and that gap has widened since. However, there is no empirical evidence linking the reduced inflation rate to prospective pricing.

(Lewis S: Speculations on the impact of prospective pricing and DRGs. West J Med 1984 Apr; 140:638-644)

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ABBREVIATIONS USED IN TEXT

DHHS = Department of Health and Human Services
DRG = Diagnosis Related Group
FAH = Federation of American Hospitals
HMO = health maintenance organization
LOS = length of stay
LTC = long-term care
PPS = Prospective Payment System
PRO = (Utilization and Quality) Peer Review Organization
PSRO = Professional Standards Review Organization
TEFRA = Tax Equality and Fiscal Responsibility Act of 1982

necessarily result in exactly the same rate for all payers, but will be closer to that objective than if some payers enjoy the advantages of prospective pricing and others do not. The PPS legislation, PL 98-21, may make it easier for states to establish their own all-payer systems. It sets forth criteria for such systems that, if met, obligate both Medicare and Medicaid to participate. This feature of the law reflects the view of the Department of Health and Human Services (DHHS) that prospective pricing contains costs only if it prevents cost shifting by including several payers.

There is some evidence that private-sector concerns over cost shifting under PPS will lead to more all-payer systems. Since passage of PL 98-21, three additional states have created hospital rate-setting commissions, and similar legislation was introduced in seven others. (Seven states already regulate hospital rates—four include Medicare under waiver, while the remaining three systems are restricted to private-sector payers.) As more hospitals come under PPS, the increasing cost shift may accelerate the passage of all-payer legislation in other states as well.

The assumption that PPS will increase cost shifting is challenged by some, notably the Federation of American Hospitals (FAH). FAH, the association of investor-owned hospitals, states that PPS will reduce costs to all payers without a formal all-payer system. The reasoning behind their argument is that in order to break even under PPS a hospital will have to make cost-cutting changes—for example, in staff productivity—that will apply to all patients, regardless of payer.

At present there is little concrete evidence to support the FAH argument, but until now there has been no way to test it empirically. As data begin to accumulate from hospitals under PPS, it should become evident whether the program is helping or hurting private-sector payers. The issue of cost-shifting may become academic if a national all-payer system is developed. Senator Edward F. Kennedy (D-Mass) and Congressman Richard Gephardt (D-Mo) are currently working on such a plan as the basis of a unified Democratic party strategy for cost containment. The program would exempt HMOs and states with their own all-payer systems. For Gephardt, this activity apparently signals a shift away from the "competition" approach.

Price Competition

Depending on the way it influences cost shifting, PPS may increase or decrease price competition among payers. If PPS increases cost shifting, larger private-sector payers will be more readily able to pass along these costs, in turn, to smaller ones. This would result from the larger payers' relatively greater ability to negotiate discounts from hospitals. Thus, the larger, stronger payers will enjoy a cost advantage that can be turned into a price advantage as well.

On the other hand, if the Federation of American Hospitals' argument is correct or if all-payer state systems reduce cost-shifting, the relatively stronger negotiating position of large payers will be weakened. The increased equity among payers in terms of cost will tend to reduce the cost advantages that can be exploited in price competition. This in turn should decrease price competition among payers.

Using national Diagnosis Related Group (DRG) values, PPS will also redistribute hospital revenues geographically from high-cost areas such as California and New England to low-cost areas like the South. A nationwide all-payer system, if structured like PPS, would reduce the influence of regional differences among carriers. Translated into costs to payers, the redistribution of hospital revenues means that regional or local payers in formerly high-cost areas will now find their costs reduced, while those in formerly low-cost areas will find theirs correspondingly increased.

Utilization Review/Quality Assurance

Under any prospective system, utilization review takes on added importance. The balance between overutilization and underutilization is critical, and utilization review is central to maintaining that balance. It produces the information a hospital needs to keep costs below the revenue ceiling while providing a high enough level of care to minimize malpractice liability.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) changed the hospital utilization review system for Medicare in ways that may increase the influence of DHHS over the process. The old Professional Standards Review Organizations (PSROs) are to be replaced by Utilization and Quality Peer Review Organizations (PROs). The differences between the two types of organizations are significant for both the provider and the payer.

From the government's point of view, the two most important changes are that (1) PROs will operate under performance-based contracts, committing themselves to meet contractually agreed upon reductions in utilization and (2) after the first year it will be possible for fiscal intermediaries to sponsor PROs. Initially, physician-sponsored groups will have preference in obtaining PRO contracts and will have a strong incentive to meet utilization-control targets in order to keep their contracts. Whether they succeed or forfeit the contracts to other groups, the government as payer will benefit from the new system.

As will be noted below, the change in utilization

review has a strong potential impact on providers as well.

These three general implications—a trend toward all-payer systems, changes in the competition among payers and payers' increased control over utilization—are by no means the only changes that can occur from PPS, but they illustrate the kind of impact it will have on payers.

Impact on Providers

Prospective pricing is intended to achieve its cost containment goals by modifying provider incentives, so it is not surprising that attention has focused on the types of impact the new system will have on them.

Hospital-Physician Relations

Probably the most obvious implication of PPS is that it will force hospitals and attending physicians to cooperate much more closely in holding down utilization. Under cost-based reimbursement, a hospital benefited financially from a physician who utilized its services heavily; the more cost-generating services he or she ordered, the more revenue the hospital obtained. Today, under PPS, that same physician is viewed as a threat to the hospital's survival; unless his practice patterns keep utilization at or below the price ceiling, the hospital can lose money.

In the hospital-physician relationship, each side must balance conflicting incentives. By training and experience the physician is inclined to use any diagnostic or therapeutic service that potentially can help the patient. This inclination is bolstered by the threat of professional liability which results in "defensive" medicine—doing "everything possible" for the patient and thereby minimizing the risk of being sued for failure to provide adequate care.

This pressure on physicians to introduce and make heavy use of hospital services is countered by the realization that their hospitals of choice are at risk for any costs over and above the DRG revenue cap. Those costs that cannot be shifted or eliminated must be absorbed and over the long run can threaten the hospital's survival. For a physician this fact raises a major concern: the loss of his or her hospital of choice as a practice setting and the potential difficulty in joining the staff of another suitable hospital. This concern is becoming more relevant as increasing numbers of hospital medical staffs are being closed to new members.

A hospital faces the same conflicting incentives. To remain competitive, it must be able to attract admissions while at the same time holding utilization (and costs) below the revenue ceiling. Like physicians, a hospital increases its liability risks by underutilization. It also knows that a competing hospital that successfully shaves costs closer to the bone will be more profitable. Competitive pressures no longer can be relieved by increasing investment and utilization, and internal conflicts may make it potentially more difficult for hospitals and physicians to reach the necessary accommodations between themselves. Unless there is greater accommodation between physicians and hospitals, however, these internal conflicts will prevent them from operating successfully under PPS. There has to be a mutual recognition of both the physicians' and the hospitals' imperatives. If either side tries to impose its will unilaterally on the other, both will lose.

Data Management

The physician-hospital cooperation required by PPS will depend largely upon the ability of both parties to understand and rely on the hospital's utilization data management system. Given that most hospitals and physicians have limited experience with the type of data base involved, this may require something of an act of faith on both their parts.

Although formal assignment of a case to a particular DRG will be done by the fiscal intermediary, hospitals will need to be able to replicate that process themselves. It is essential to know, as early after admission as possible, how much the hospital will be paid for a particular case. The hospital must choose among vendors of case-mix software, many of which themselves have limited experience in this area. The data base will be only as good as the medical records and billing data merged into it. Thus, the hospital must also rely on the physician and on its own internal recordkeeping. The physician, in turn, must rely on the PRO that will use the data to make judgments about his or her practice patterns.

This heavy reliance on relatively new types of data places substantially greater power in the hands of those who generate and manage the data base. These include at least the review nurse, the physician who is responsible for the completeness and accuracy of the medical record, the medical record administrator, the cost analyst in the business office and the data processing manager. Each of these people will command new leverage in dealing with other players in the system. They will be able, over time, to influence the operation in ways that facilitate and emphasize the gathering and use of the information they control. In other words, data-base management will become something of an end in itself as it becomes more crucial to achieving other hospital objectives.

Capital Allocation

There is a consensus that prospective pricing will reduce or retard capital expenditures by hospitals. Under traditional cost-based reimbursement, capital costs could be passed through to the payer, so there was little incentive to control the amount of capital investment or the cost of money. Under PPS, however, capital costs (after the phase-in period) will have to be covered by the DRG payment. New technology is accommodated by PPS in only limited ways; one percentage point is added to the hospital "market basket" inflator for technological upgrading, and DRGs are to be reexamined at least every four years, partly to determine whether the spread of new technology has rendered any classification obsolete.

Capital investments usually will have to show po-

tential to generate a net savings to the hospital. Moreover, the cost of capital itself can be expected to increase. Not-for-profit hospitals tend to rely heavily on bonded indebtedness, and their bond ratings will deteriorate if their operating margins are reduced by prospective payment. For-profit hospitals derive more of their capital from the sale of stock, but reduced profitability and new Medicare limits on allowable return on equity may make them less attractive to investors. Profitability will be especially affected by the fact that prospective pricing discourages utilization of ancillary services: under cost-based reimbursement, proprietaries earned substantially more margin on such services than did not-for-profits.

It has been said that the capital squeeze will hurt for-profits more than not-for-profits. The loss of profits from ancillary services is cited as one reason; another is that not-for-profits have more "fat" to trim from their staffing patterns. If a recent legislative proposal passes, proprietaries will also be severely restricted in access to the Industrial Development Bond market.

The other side of this argument is that for-profit hospitals will maintain their competitive advantage because of their location (mainly prosperous suburbs of growing cities in loosely regulated sunbelt states), payer mix (low proportions of Medicare/Medicaid and bad debt), case mix (emphasizing elective surgical procedures) and management efficiencies (tight staffing, large-scale purchasing). This could give them easier access to capital markets.

It remains to be seen whether proprietaries will suffer more than non-profits from reduced access to and increased cost of capital. For that matter, it is not clear that the net effect of reduced investment will necessarily be negative. One analysis has shown that every dollar of hospital capital investment generates $1.84 in added operating costs. For a hospital whose profit-maximizing strategy now must rely more heavily on reduced costs, capital investment will be much less attractive than in the past.

Organizational Structure

Prospective pricing can be expected to change the corporate structures of hospitals. Two changes in particular seem likely to become widespread.

First is corporate restructuring of autonomous not-for-profit hospitals. There will be much stronger incentives for those institutions to form foundations, umbrella corporations or other entities that can engage in for-profit business without jeopardizing the tax-exempt status of the hospital itself. Such entities not only can generate added revenue but also can raise capital by selling stock. Other uses of restructuring are to form chains from independent units and to facilitate shared services (group purchasing, for example).

A second likely type of organizational change will be vertical integration. Acute care hospitals will seek to gain control over long-term care (LTC) facilities either by purchases, lease, construction, partial relicensure ("swing beds") or some other method. The incentive to do so comes from the relative shortage of LTC beds, combined with the revenue ceiling under PPS. Under the old cost-based reimbursement system a Medicare patient may have been ready for transfer to an LTC facility, but if an LTC bed was unavailable the acute-care hospital was not reimbursed for the waiting days. Under PPS, there is even stronger pressure to reduce acute-level length of stay so it will be increasingly important for the hospital to control access to a supply of LTC beds. Arranging such a relationship with an LTC facility will be easier for a hospital that has undergone corporate restructuring and has an appropriate entity in place to connect the two institutions.

Specialization by DRG

There is some evidence that as a hospital learns which services are profitable for it to provide, it will seek to maximize use of those services and avoid "loss leaders" or unprofitable services. This is more likely to occur under an all-payer system, but could apply to PPS as well. A relatively simple method for doing so is to employ the preferred provider concept. Once a hospital has identified its profitable services (or DRGs within a service) it offers a discount on them (at a still-profitable level) to third-party payers (in this case, Medicare). Tied to this contract may be some obligation for the payer to steer patients elsewhere for money-losing services. At present such a practice would be illegal in some states, but specialization has begun to appear on a small scale in New Jersey.

Selective contracting by DRG would be attractive to a hospital if (1) its most profitable DRGs could bring in enough patient volume to meet its revenue needs and (2) there were little competition from other hospitals for the same DRGs. In practice, however, a DRG can be extremely profitable on a per-case basis, while being limited to one or two cases per year. Moreover, a particular DRG that is profitable for one hospital may well be even more so for its competitor across town. Finally, the surplus of beds in many highly competitive markets may make specialization a luxury that hospitals cannot afford. For those hospitals it will be necessary to do just the opposite—to offer every service they can in order to "capture its contribution" to fixed costs. The reasoning here is that as long as the payment exceeds the variable costs of providing a service, it should be provided (as long as there is unused capacity) because it is also making some contribution to covering fixed costs. Given the high ratio of fixed to variable costs in hospitals and the unused capacity available in many institutions, the need to recover fixed costs will make specializations by DRG impractical for many of them.

Medical Staff Relations

The shrinkage of capital and possibility of DRG specialization have implications for relationships within a hospital's medical staff. Different departments within the staff now will have to compete more directly with each other for capital and other hospital resources. Just as the hospital will identify individual physicians who

generate a net cost or profit, the same will be true of entire services. Capital and other resources (such as bed capacity and operating room time) will flow to those services that can show they will use such resources more profitably than other departments or services. It will not be enough just to show that a new technology or other investment for use by one medical staff department will generate net savings or profit; it must generate greater savings than could another department's use of the same funds.

In the past this form of competition has been minimized by a number of factors. Both the capital costs and increased operating costs associated with a new technology or other investment could be passed through to payers. There was also the danger that competing institutions could lure admissions away by providing the same new service. These factors, working together, encouraged a hospital to invest in technology regardless of its cost-effectiveness. Some investments in new technology were acknowledged loss leaders to attract lucrative admissions or generate billable ancillary services.

Obviously no hospital has access to unlimited capital; however, there were fewer constraints against investment under the old system, so potential conflict over limited resources was reduced by making more resources available. When conflict could not be avoided that way, internal politics within the medical staff often dealt with it informally. Both of these options are severely limited under PPS.

Utilization Review

The impacts of changes in utilization review on the payer have already been noted. These changes will have an even stronger influence on hospitals and physicians.

First, PROs can be expected to be more aggressive than the old PSROs in terms of utilization control. Some PROs will be for-profit entities, and all of them will have an incentive to meet their contractual targets for reducing admissions under certain DRGs.

Second, utilization review will produce the data that will pinpoint the DRGs and individual physicians who generate profits and losses for the hospital. This will be invaluable to a hospital in its strategic planning, but will place a great deal of pressure on a physician whose practice pattern (or, perhaps, specialty) represents a net cost to the hospital.

Third, the focus of review will now be much broader. Under cost-based reimbursement, the payment unit was the individual billed services (one day's inpatient room charge, an individual medication and the like), so utilization review was concerned with the appropriateness of the individual service. Under PPS, the payment unit is the admission, so utilization review will be concerned with the appropriateness of the admission and of the DRG to which it is assigned.

Finally, utilization review is the physician's first line of defense in resisting pressure to curtail services. In addition to its traditional role of policing overutilization, it will now be responsible for preventing *under*utilization as well.

DRG Pricing and Payment

The method of calculating the payment rate for each DRG probably will have stronger impact on providers than any other element of the system. This impact will not be fully felt until the end of the three-year phase-in period, but it can be easily anticipated already.

Perhaps the major single effect is the imposition of national urban and rural rates for each DRG. High-cost hospitals will lose all the money that low-cost hospitals will gain. Some entire regions, such as California or New England, will find most of their PPS hospitals suffering reduced reimbursement. These hospitals and, by extension, the markets they serve, will have reduced access to capital, greater risk of closure and, probably, a gradual emigration of health care professionals. Conversely, low cost hospitals and those in low-cost areas will have improved cash flow, access to capital and a larger pool of qualified personnel. These effects will be strongest in the early years after the end of the phase-in period.

Of course, under PPS these effects will be felt only to the extent of Medicare involvement and they would probably be lessened by state all-payer systems. Nonetheless, regional redistribution of some 36% of hospital revenues will be a major change for both the winners and losers. There are other sorts of impact of the payment system as well. At present, for example, the PPS phase-in calls for retention of the urban-rural wage differential. This can create anomalies in areas where "rural" and "urban" hospitals must compete for the same workers. Similarly, several data elements in calculating the reimbursement formula will be changed on October 1 of each year during the phase-in period—this despite the fact that some hospitals' PPS years begin as late as July 1.

Some effects cannot be predicted beyond the phase-in period. For example, the method of integrating capital costs into the DRG rate formula has yet to be determined. Some methods, like the flat percentage add-on recommended by the American Hospital Association, would tend to help institutions in the Northeast at the expense of those in the South. This would presumably occur because institutions in the South now spend more on capital investments relative to revenue than those in the rate-regulated states of the Northeast.

Gaming

Any system that is not absolutely rigid can be manipulated. There are a great many actions a hospital can take to maximize reimbursement under PPS. Some of these will be discussed in terms of their effects on patients, but two forms of "gaming," or manipulation, are particularly relevant here: DRG "creep" and unbundling.

DRG creep involves the subtle shift upward from lower-cost categories to higher-cost ones. At some levels DRG creep is an ethical tactic. If a patient has two or more equally valid conditions that might be listed as principal diagnosis, it is legitimate to select the one that leads to the higher-paying DRG. On the other

hand, it would be unethical to select the principal diagnosis strictly on the basis of its DRG value.

Unbundling involves divestiture of hospital functions (such as laboratory or radiology facilities) in order to minimize the costs that must be covered by the DRG payment. This, too, would be unethical, and a large portion of the PPS regulations is devoted to preventing it.

Impacts on the Patient

Hospitals and physicians are in the business of providing health care, not gaming PPS, and the impacts of PPS on patients must be viewed in that perspective. Granted, every hospital must generate an operating surplus; for nonprofit institutions, the main reason is to be able to continue offering hospital care, and in a sense the same is true of many investor-owned institutions as well. They are profitable in part because there is a market niche (that is, sufficient ongoing demand for health care) that makes them more profitable than alternative uses of the same capital. In that context, there are a number of ways in which patients will be affected by hospitals' efforts to maximize profit under PPS.

Length of Stay

DRGs rely on length of stay (LOS) as a surrogate measure of resource use. It is therefore likely that hospitals will look to reducing LOS as a major source of savings. Under PPS, restricted to Medicare, this approach makes more sense than for other payers. While a typical patient's costs are concentrated early in the hospital stay, those of Medicare patients are more evenly spread over the course of the stay.

The strictly economic incentive to reduce LOS is strongest in areas with the highest per-diem costs. Unfortunately, some areas with high per-diem cost, such as California, already have shorter LOS than others. Thus it will be difficult to reduce LOS further without jeopardizing the patients' treatment outcome. The New Jersey Medical Society is investigating a group of post-discharge deaths in that state to determine whether discharge was premature in those cases.

LOS can also be manipulated by transfer. If the second hospital is also under PPS, as is most often the case, it receives the DRG payment and the first hospital is paid a prorated per-diem rate. Thus if the first hospital can make money at the per-diem rate, it behooves it to hold patients as long as possible before transferring; otherwise, it will want to transfer them as early as possible.

Another variation is readmission. If a patient could be admitted under either of two diagnoses, it may be possible to admit and quickly discharge him under one of them, collect the DRG payment for that stay, and then readmit under the second diagnosis.

Clearly, any manipulation of LOS will be subject to strict Peer Review Organization scrutiny and it will be difficult for a hospital to abuse it on a large scale. Nevertheless, to the extent it does occur, it can affect the quality of care.

Ancillary Services

Another area of savings will be reduced use of ancillary services. Redundant or "backup" diagnostic procedures will be reduced, placing a premium on the accuracy of those carried out. Similarly, therapies that cannot be shown to be cost effective may be eliminated, even if marginally beneficial to patients.

More significant, however, new diagnostic and therapeutic technologies will be much more slowly adopted than in the past. The requirement that it generate a net savings will become the test of virtually every new technology. Given the increased cost of capital in the future and new technology's greater burden on operating costs, this will be a formidable hurdle indeed. Furthermore, the competitive pressure to adopt new technology is reduced by the fact that a hospital's competitors are in the same situation. It seems reasonable to assume that over time there will be a ripple effect backward from the medical technology marketplace to research and development. As demand slows, so will the rate of new product development.

Availability of Care

Research indicates that a hospital's chances of survival have little to do with management efficiency. No matter how good a hospital is at reducing controllable costs, its fate is likely to be determined by factors beyond its control. In practice this means, unfortunately, that the hospitals that are most threatened are those serving people who have nowhere else to go. Two categories are especially vulnerable: inner-city and rural public hospitals.

The main threat to these hospitals is the burden of unreimbursed or underreimbursed care. As the last resort source of care, county hospitals carry a heavy Medicare/Medicaid and MIA (medically indigent adult) caseload at less than full-cost payment, as well as largely unpaid care of indigents who are not covered by government programs. Because of location and/or competition from private institutions, they cannot attract sufficient insured or self-pay patient loads to make up their deficits. Inner-city hospitals suffer further from high operating costs (such as for labor and security), while rural institutions often have insufficient volume to spread costs adequately.

While these problems are most severe for the types of hospitals described above, they affect others as well. Autonomous nonprofit hospitals in particular, with Hill-Burton or corporate charter obligation to provide charity care, are vulnerable even in relatively prosperous areas.

Prospective pricing can be expected to aggravate this problem in high-cost areas. The impact of PPS will depend on how large a private-sector caseload a hospital has in order to accept the shifted costs. The ability to shift Medicare costs becomes more crucial under the PPS revenue cap than under cost-based reimbursement,

so the hospital that lacks a large private-sector caseload is now in an even worse position if it is unable to bring its costs below the DRG rate caps. For a patient in such a hospital, this can mean more severely reduced services than in others or possibly eventual closure of the only source of care. Either way that patient will feel the impact of the new system more sharply than patients in stronger hospitals.

Regional differences will also appear, at least in the years just after the switch to the nationwide DRG rate. Even the most stressed hospitals in low-cost regions will feel some relief as revenues, at least on a regional basis, exceed costs. Conversely, even the relatively secure institutions in high-cost areas will be strained to cover costs, and those already in trouble will be even more so.

Out-of-Pocket Costs

Increased future patient cost-sharing is virtually inevitable under any payment system. Under PPS, the Medicare cost shift will accelerate this trend. Further, the "budget neutrality" requirement during the phase-in will likely lead to some cost-shifting, although the impact of this may not be felt immediately. For example, DHHS includes a "fudge factor" to allow for the effects of gaming. However, if the TEFRA target is not met in one federal budget year, the difference will probably be made up in succeeding years by reducing the DRG rate.

Summary

Prospective pricing seeks to reduce costs by changing provider incentives. By setting payment ceilings and letting providers know what those ceilings are, the system sets cost-control targets that a provider must meet over the long term.

Equipped with this knowledge, a hospital must seek cooperation from physicians, who typically control about 70% of hospital costs. Physicians must balance the patients' quality-of-care needs with the hospital's economic viability.

The effects of cost-containment efforts by payers, implemented by providers, are distilled in their impacts on patients. There are strong incentives for providers to reduce services and length of stay, and it will be some time before it becomes clear how much this will affect the quality of care. For some patients, however, the more immediate issue will be whether any care is available at all, regardless of quality.